PRE-APPLICATION TO MEDICAL STAFF

The purpose of this questionnaire is to verify that your credentials are in good standing with the appropriate licensing board, National Practitioner Data Bank, and other associations before an authorized approval and hiring determination is made.

All licensed independent practitioner applicants who are applying for the positions listed below, or the equivalent of those positions, must complete this form. **Fax the completed form, along with your CURRENT Curriculum Vitae and other requested documents, to the California Department of Corrections and Rehabilitation (CDCR) Credential Coordinator at (916) 324-6763.** If you have any questions, the agent may be reached by telephone at (916) 327-3336.

TO PREVENT UNNECESSARY DELAYS IN PROCESSING YOUR APPLICATION, PLEASE PRINT LEGIBLY AND PROVIDE ALL REQUESTED INFORMATION.

Application for the Position of: ☐ **Physician Assistant**

Name: Last: _____ First: _____ Middle: _____

Other Names Used: _____ Gender: ☐ Female ☐ Male

Full Social Security Number: _____ Date of Birth: _____

Home Address: _____
Street Address City State Zip Code

Contact Information: _____
e-mail address phone numbers

United States Citizen: ☐ Yes ☐ No. If no, what kind of visa will you hold while you are here?

Type: _____ Sponsor: _____ Expiration Date: _____

If you hold permanent immigrant status in the U.S., please attach a copy of your green card or approval letter.

National Identification number: _____ Country of Issue _____

Professional school(s) (nursing or medical degrees):

Name	Degree	Year Graduated

Professional license(s)/certifications/registrations (medical, nurse practitioner, physician assistant):

License number: _____ State: _____ License number: _____ State: _____

License number: _____ State: _____ License number: _____ State: _____

License number: _____ State: _____ License number: _____ State: _____

Name of Specialty Residency _____

Board eligible: ☐ Yes ☐ No If Yes, name of Board: _____

Board certified: ☐ Yes ☐ No If Yes, Board: _____

Most recent year certified/recertified: _____

DEA Number: _____ Expiration Date: _____

BLS Certification: _____ Expiration Date: _____
(Please attach a copy the certificate to this application)

ANY AFFIRMATIVE ANSWER TO QUESTIONS ONE THROUGH 18 REQUIRES ADDITIONAL INFORMATION ON A SEPARATE PIECE OF PAPER, ELABORATING UPON THE RESPONSE AND DESCRIBING THE CIRCUMSTANCES INVOLVED.

1. Have any disciplinary actions been initiated or are any pending against you by any state licensure board? □ Yes □ No
2. Has your license to practice in any state ever been relinquished, denied, limited, suspended, or revoked, whether voluntarily or involuntarily? □ Yes □ No
3. Have you ever been asked to surrender your license? □ Yes □ No □

☐ Additional information is attached for the above section (questions ___, ____, ___)

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4. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (for example Medicare, CHAMPUS, or Medicaid)? □ Yes □ No
5. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program? □ Yes □ No
6. Has your federal or state narcotics registration certificate ever been relinquished, limited, denied, suspended, or revoked? □ Yes □ No
7. Is your federal or state narcotics registration certificate currently being challenged? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ____, ___)

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8. Have you ever been named as a defendant in any criminal proceedings? □ Yes □ No
9. Has your employment, Medical Staff appointment, or clinical privileges ever been suspended, diminished, revoked, refused, or limited at any hospital or other health care facility, whether voluntarily or involuntarily? □ Yes □ No
10. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the Medical Staff before the hospital or health facility's Board made a decision? □ Yes □ No
11. Have you ever been the subject of focused individual monitoring at any hospital or health care facility? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ____, ____)

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12. Have any profession liability claims or suits ever been filed against you or are any presently pending? □ Yes □ No
13. Have any judgments or settlements been made against you in professional liability cases? □ Yes □ No
14. Had your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? □ Yes □ No
15. Has any information pertaining to, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ___, ___)

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16. Do you have any financial interest (directly or through family or business partners) in any nursing home, laboratory, pharmacy, medical equipment, or supply house or other business to which patients from the CDCR might be referred or recommended?
17. Are you able to perform all the services required by your agreement with, or the professional bylaws of, the Division of Correctional Health Care Services to which you are applying, with or without reasonable accommodation, according to the accepted standards of professional performance and without posing a direct threat to the safety of patients? □ Yes □ No
18. Did you change medical schools and/or residency programs? □ Yes □ No
19. Does your curriculum vitae show any gaps in training or practice greater than 3 months in duration? □ Yes □ No
20. Have you ever been examined by any specialty board and failed to pass the examination? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ___, ___, ___)

FOR QUESTIONS 21, AND 22, PROVIDE ADDITIONAL INFORMATION ON A SEPARATE PIECE OF PAPER WHEN DIRECTED TO DO SO AS A RESULT OF YOUR ANSWER

21. If not currently certified, have you applied for: ☐ **Physician's Assistants**: National Certification? ☐ Yes ☐ No
☐ **Physicians**: Family Medicine or Internal Medicine: ☐ Yes ☐ No
☐ **Nurse Practitioners**: Adult or Family Medicine: ☐ Yes ☐ No.
If not, do you intend to apply for the relevant certification exam? ☐ Yes ☐ No.
If no, please explain why on a separate piece of paper. ☐ Additional information attached.

22. Have you been accepted to take the relevant certification exam? ☐ Yes ☐ No
If yes, what dates are/were you scheduled to take the certification exam?

APPLICANT'S AUTHORIZATION AND RELEASE

I hereby attest that the information in or attached to this application is true and complete. Any misrepresentation, misstatement, or omission from this pre-application, whether intentional or not, may constitute sufficient cause for rejection of this pre-application resulting in denial of provisional clinical privileges.

I hereby authorize the CDCR, its medical staff, and their representatives to consult with any representative(s) of the medical/professional or administrative staff of any health care organizations with which I have or have had employment, practice, association, or privileges and any other organizations (including without limitation state licensing boards, professional associations, and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications, and to inspect such records that shall be material to the evaluation of my professional qualifications and competence to carry out the privileges I am requesting as well as to my moral and ethical qualifications.

I authorize and request my medical malpractice liability insurance carrier, past and present, to release information to the CDCR, its medical staff, and their representatives regarding any claims or actions for damages pending or closed, whether or not there has been a final disposition.

I hereby release from liability all individuals and organizations that provide said information to the CDCR, medical staff, and their representatives in good faith and without intentional fraud, and I hereby consent to the release of such information.

A photocopy of the release shall be valid as an original. This is a request to obtain additional information, not a commitment to hire.

Please Note: This authorization shall expire upon separation from CDCR or within twelve months of the date below, in the event that no employment is offered and accepted.

_____ _____

Signature of Applicant Date

PHYSICIAN ASSISTANT CLINICAL PRIVILEGES

Name:_____ Effective from __/__/__ to __/__/__

Applicant: *Check off the "Requested" box for clinical privilege requested. New applicants may be requested to provide documentation of the number and types of clinical cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Division of Correctional Health Care Services (DCHCS) for a proper evaluation of current competence, and other qualifications and for resolving any doubts.*

Professional Practices Executive Committee Chairperson (PPEC) or Designee: *Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.*

Qualifications for Physician Assistant (PA)

Initial Applicant - To be eligible to apply for initial clinical privileges as a PA, the applicant must meet the following criteria:

Successful completion of an approved program that conforms to the Physician Assistant Committee of the Medical Board of California standards for PAs,

AND

Current active licensure to practice as a PA in the State of California;

AND

Current DEA Registration,

AND

Current demonstrated competence and an adequate level of current experience, documenting the ability to provide services at an acceptable level of quality and efficiency;

AND

Current certification by the National Commission on Certification of Physician Assistants, or be actively seeking certification and obtain the same on the first examination for which s/he is eligible, or successful completion of an examination as required by the DCHCS,

AND

Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the DCHCS GB, or indemnification by the State of California,

AND

Completion of a Delegation of Services Agreement with a supervising physician(s) privileged at a DCHCS Institution, who is responsible for the inmate-patients cared for by the PA.

PHYSICIAN ASSISTANT CLINICAL PRIVILEGES

Name:_____ Effective from __/__/__ to __/__/__

Special Services/Procedures: Successful completion of an approved, recognized course when such exists, or acceptable supervised training, and documentation of competence to obtain and maintain services as set forth in policies governing allied health professionals and the provision of specific services, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that PA. The PA shall consult with a physician regarding any task, procedure, or diagnostic problem, which the PA determines, exceeds his or her level of competence or shall refer all such cases to a physician. A PA may be trained to perform medical services that augment his or her current areas of competency. Training shall meet the requirements of California Code of Regulations, Title 16, Section 1399.543. Prior to delegating any surgical procedure customarily performed under local anesthesia, the supervising physician shall review documentation that indicates the PA is trained to perform the surgical procedure. The PA may perform all other surgical procedures requiring other forms of anesthesia only in the personal presence of a supervising physician. A PA may also act as first or second assistant in surgery under the supervision of a supervising physician.

Supervision: The exercise of these specified services require a designated supervising physician with clinical privileges at this Institution. All practice is performed under the supervision of this physician and in accordance with written policies governing inmate-patient care and protocols approved by the PPEC and DCHCS GB. The supervising physician shall be available in person or by electronic communication at all times when the PA is caring for inmate-patients. The supervising physician shall review, countersign, and date a minimum of 10% sample of medical records of inmate-patients treated by the PA functioning under these protocols within thirty (30) days. The supervising physician shall select for review those cases, which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the inmate-patient.

Categories of Patients Practitioner May Treat: May provide those medical services which he or she is competent to perform as determined by the supervising physician, are consistent with his/her education, training and experience, and are consistent with the standardized procedures and the policies stated herein, to the California Department of Corrections and Rehabilitation (CDCR) inmate-patient population of the supervising physician with whom the PA has a documented formal affiliation. PAs may not admit inmate-patients to the licensed inpatient setting.

Medication Ordering and Administration Responsibilities: The PA may administer medication to an inmate-patient, or transmit orally, or in writing on a unit health record, a prescription from his or her supervising physician to a person who may lawfully furnish such medication or medical device. The prescription shall be based on either an inmate-patient specific order by the supervising physician, or on a written protocol that specifies all criteria for use a specific drug or device and any contraindication to the selection, The unit health record of any inmate-patient cared for by the PA for whom the supervising physician's prescription has been transmitted or carried out, shall be reviewed and countersigned and dated by a supervising physician with seven (7) days. A PA may not administer, provide or transmit a prescription for Schedule II controlled substances , without patient specific authority by a supervising physician. "Patient specific authority" means that after the PA sees a patient and determines that a Schedule II drug is needed, the PA has to contact the supervising physician and request permission to give that Schedule II drug to that particular patient.

Medical Record Charting Responsibilities: Clearly, legibly, completely, and in timely fashion, describe each service the PA provides to an inmate-patient in the Institution and relevant observations. Standard rules regarding authentication of, necessary content of, and required time frames for preparing and completing the medical record and portions thereof are applicable to all entries made. Each time the PA provides care for an inmate-patient and enters his or her name, signature, initials, or computer code on a unit health record, chart, or written order, the physician assistant shall also enter the name of his or her approved supervising physician who is responsible for the inmate-patient. When the PA transmits a verbal order, he or she shall also state the name of the supervising physician responsible for the inmate-patient.

General Relationship to Others: PAs have authority to direct any institution health care personnel in the provision of clinical services to inmate-patients to the extent that such direction is necessary in order to carry out the services required by the inmate-patient and which the PA is authorized to provide.

Periodic Competence Assessment: Applicants must also be able to demonstrate they have maintained competence based on unbiased, objective results of care according to the Institution's existing quality assurance mechanisms. PAs shall recertify at the interval required to maintain continued certification with the National Commission for the Certification of PAs. PAs shall complete Continuing Medical Education as required to remain certified.

PHYSICIAN ASSISTANT CLINICAL PRIVILEGES

Name:_____ Effective from __/__/__ to __/__/__

PHYSICIAN ASSISTANT CLINICAL PRIVILEGES – PRIMARY CARE

❑ Requested

Adult inmate-patients within the inpatient and outpatient settings except as specifically excluded from practice:

- Interview inmate-patients and compile complete and accurate medical/social histories
- Perform routine physical examination including rectal and pelvic examination as indicated
- Observe and evaluate inmate-patient's emotional condition
- Diagnose medical conditions and recognize and evaluate situations that require immediate attention or consultation with a physician
- Initiate, when necessary, treatment procedures essential for preserving the patient's life
- Initiate, review and revise treatment and therapy plans including plans for services and record and present pertinent data in a manner meaningful to the physician
- Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy and nursing services
- Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures, and therapeutic procedures
- Administer medication to the inmate-patient, or transmit orally or in writing on an inmate-patient's unit health record, a prescription from his or her supervising physician.
- Perform surgical procedures without the personal presence of the supervising physician, which are customarily performed under local anesthesia.
- Counsel and instruct patients regarding matters pertaining to their physical and mental health
- Monitor and manage stable chronic illnesses of population served
- Initiate and facilitate referrals to appropriate physician or other health care professionals or facilities as appropriate
- Make rounds on patients with, or at the direction of, the supervising physician
- Perform primary health care maintenance of the population served
- Write discharge summaries

PHYSICIAN ASSISTANT CLINICAL PRIVILEGES

Name:_____ Effective from __/__/__ to __/__/__

Qualifications for PA Clinical Privileges – Obstetrics / Gynecology Care

To be eligible to apply for core privileges as a PA with clinical privileges in Obstetrics / Gynecology, the applicant must meet the following criteria:

Applicant must satisfy the qualification requirements for PA,

AND

Documented training and experience in obstetrics / gynecology care and demonstrated current competence.

Periodic Competence Assessment: Applicants must also be able to demonstrate they have maintained competence based on unbiased, objective results of care according to the institution's existing quality assurance mechanisms.

PHYSICIAN ASSISTANT CLINICAL PRIVILEGES - OBSTETRICS / GYNECOLOGY
(Includes PA Clinical Privileges -Primary Care)

☐ **Requested**

Provide services for female adult patients within the inpatient and outpatient settings except as specifically excluded from practice that include the following:

- Care before and after menopause
- Contraceptive care
- Evaluation and treatment of common vaginal infections
- Health and wellness counseling
- Norplant removal
- Perform physical exams, including rectal exams and Pap smears
- Pregnancy testing and care before, during, and after pregnancy
- Screen and refer for other health problems including suspected sexual abuse, rape
- STD screen and follow up

PRESCRIPTIVE AUTHORITY AS DELEGATED BY A SUPERVISING PHYSICIAN IN A DELAGATION OF SERVICES AGREEMENT IN ACCORDANCE WITH STATE LAW

❒ Requested: DEA Schedule II

Criteria: Possession of a current Furnishing Number from the State of California, and current DEA registration.

PHYSICIAN ASSISTANT CLINICAL PRIVILEGES

Name:_____ Effective from __/__/__ to __/__/__

SPECIAL NON-CORE PRIVILEGES (See Qualifications and/or Specific Criteria Below)

COLPOSCOPY

❒ Requested

Criteria: Documented training or experience to include colposcopy.

Required Previous Experience: Demonstrated current competence and evidence of the performance of at least 10 colposcopy procedures in the past 24 months or proctoring for the first 10 procedures by a CDCR gynecologist.

Maintenance of Privilege: Demonstrated current competence and evidence of the performance of at least 10 colposcopy procedures in the past 24 months based on results of quality assessment/improvement activities and outcomes.

ENDOMETRIAL BIOPSY

❒ Requested

Criteria: Documented training or experience to include endometrial biopsy.

Required Previous Experience: Demonstrated current competence and evidence of the performance of at least 10 endometrial biopsy procedures in the past 24 months or proctoring for the first 10 procedures by a CDCR gynecologist.

Maintenance of Privilege: Demonstrated current competence and evidence of the performance of at least 10 endometrial biopsy procedures in the past 24 months based on results of quality assessment/improvement activities and outcomes.

ULTRASOUND FOR FETAL POSITIONING

❒ Requested

Criteria: Documented training or experience in ultrasound for fetal positioning.

Required Previous Experience: Demonstrated current competence and evidence of the performance of at least 10 ultrasounds for fetal positioning procedures in the past 24 months or proctoring for the first 10 procedures by a CDCR gynecologist.

Maintenance of Privilege: Demonstrated current competence and evidence of the performance of at least 10 ultrasounds for fetal positioning procedures in the past 24 months based on results of quality assessment/improvement activities and outcomes.

PHYSICIAN ASSISTANT CLINICAL PRIVILEGES

Name:_____ Effective from __/__/__ to __/__/__

Acknowledgement of Practitioner

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at the California Department of Corrections and Rehabilitation (CDCR), and I understand that:

(a) In exercising any clinical privileges granted, I am constrained by CDCR, DCHCS, and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signed:_____ Date:_____

PPEC Chairperson Recommendation

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

❑**Recommend requested clinical privileges**

❑**Recommend clinical privileges with the following conditions/modifications:**

❑**Do not recommend the following requested clinical privileges:**

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

_____

_____

_____

PPEC Chairperson or Designee Signature_____ Date_____

PPEC Chairperson or Designee Name (print)_____